July 31, 2002

Ms. Marge Watchorn
Center for Medicare and Medicaid Services
Center for Medicaid and State Operations
Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Ms. Watchorn:

Massachusetts is pleased to submit an application for a stand-alone 1115 Demonstration Project to provide pharmacy services to people who are 65 or older with incomes at or below 188% of the federal poverty line who are not otherwise eligible for MassHealth. Under separate cover, the Commonwealth is also seeking to amend its current 1115 Demonstration Project (Project No. 11-W-00030) to provide pharmacy services to disabled individuals, under age 65 with incomes at or below 188% of the federal poverty line who are not otherwise eligible for MassHealth.

We look forward to working with you towards the approval of this exciting waiver proposal. If you should need further information to process this request, please contact Beth Waldman of my staff at (617) 210-5371.

Sincerely,

Wendy E. Warring
Commissioner

Enclosure

cc: Patricia Hitz McKnight, CMS Region One

I. Executive Summary

The Massachusetts Division of Medical Assistance (DMA), or the Division, in collaboration with the Massachusetts Executive Office of Elder Affairs (Elder Affairs), proposes to provide comprehensive pharmacy benefits to low-income seniors under a new 1115 Research and Demonstration Waiver. This new 1115 Demonstration Waiver is intended to enable the state to serve all low-income elderly found eligible, who might otherwise be underserved in the future due to expected limits in state fiscal resources.

The population eligible under this waiver would consist of Massachusetts' residents with incomes at or below 188% of the federal poverty level (FPL) who are not eligible for MassHealth and who are age 65 or older. This waiver would provide unlimited prescription drug coverage only after members exhaust any other source of prescription drug coverage. All members would pay co-payments. Benefits provided through this waiver would include comprehensive pharmacy benefits, administered by the Elder Affairs under an interagency service agreement with DMA. Prescription drug coverage will also be provided through Elder Affairs to populations not covered in this stand alone waiver request, including low income qualified individuals with disabilities. The Commonwealth will be requesting to include these prescription drug benefits for the disabled population under Massachusetts' existing comprehensive 1115 Waiver through a separate amendment process.

The Commonwealth hypothesizes that if elderly individuals who are at or below 188% FPL have seamless and affordable access to medically necessary prescription drugs, then cost reductions will be realized by the Medicaid program over time. The cost reductions would be realized from a decrease in premature reliance on the Medicaid program due to avoidable deterioration in health conditions, reductions in utilization of community or institutional long-term care services, and delays in individual spend downs into the Medicaid program. Further, savings could also extend to the Medicare program because there would be similar reductions in acute hospitalizations, visits to specialty care physicians would be reduced, and frail elders would be maintained longer in their community based settings.

Under this new 1115 Research and Demonstration Waiver, the Commonwealth would evaluate and quantify the cost of providing outpatient prescription drug coverage and the assumed decrease in need for reliance on publicly funded health care programs for the target population. The results of the demonstration project could provide valuable data to support the development of a broad-based outpatient prescription drug insurance program for Medicare beneficiaries.

II. Program Overview

Prescription drugs are an essential component of medical treatment[1] and primary care. Unfortunately, rising prescription drug costs combined with the lack of access to third-party payers of prescription drug benefits act as a barrier to obtaining prescription drugs for many people who are elderly and disabled. According to the Kaiser Family Foundation's "Prescription Drug Trends: A Chartbook Update," the annual increase in national expenditures for prescription drugs has been more than double those for other services such as hospital and physician care. At the same time, access to insurance that covers prescription drugs is dropping. The Kaiser Family Foundation found that, in 1998, 27% of elderly and disabled Medicare beneficiaries lacked prescription drug coverage. The report contends that the number of elderly and disabled Medicare beneficiaries without prescription drug coverage has likely risen in recent years as sources of third-party prescription drug payers such as Medicare + Choice program have been reduced in scope. For low-income elderly and disabled populations, the lack of prescription drug insurance often translates to lower use of this increasingly critical medical service. For example, Medicare beneficiaries under 100% of the federal poverty line (FPL) who do not have prescription drug coverage use only one-half as many drugs as those who do have such coverage[2].

The lack of access to prescription drugs among the elderly and disabled not only amounts to poor medical care but may also translate into an additional burden on public health care programs. For example, individuals who pay high drug costs will likely "spend down" to become eligible for Medicaid more quickly than those who have prescription drug coverage. Additionally, those who do not take needed medication may end up using higher cost services paid for by Medicare, Medicaid or the Disproportionate Share Program when their untreated medical problem reaches a critical state. Increasing the availability of prescription drug coverage for the elderly and disabled may improve the quality of their primary care benefits and the overall healthcare available to these individuals. It may also help to significantly relieve the financial burden that this lack of access places on other publicly-funded programs.

The Commonwealth of Massachusetts has aggressively responded to the lack of access to prescription drugs among the elderly and disabled in the state. Massachusetts has been providing access to prescription drugs to low-income elderly and disabled since 1996, with the inception of the Pharmacy Program (formerly, the Senior Pharmacy Program), a limited pharmacy benefit program available to low-income elders. As of April 1, 2001, Prescription Advantage replaced the Pharmacy Program and became available to all elders age 65 and over, as well as certain disabled individuals[3] to help offset the growing costs of their prescription drugs. Prescription Advantage, administered by the Executive Office of Elder Affairs, has an extensive formulary, no income restrictions for people age 65 or older, and is structured in an insurance model. Although not included in this waiver

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[1] Kaiser Family Foundation "Medicare Chartbook," December 2001

[2] Kaiser Family Foundation "Prescription Drug Trends: A Chartbook Update," November 2001

[3] Those not eligible for Medicaid under current 1115 waiver because they are non-working and must first meet one-time deductible.

request, DMA is proposing to include qualified individuals with disabilities in Massachusetts' existing comprehensive 1115 Waiver through a separate amendment process.

A. Proposed 1115 Waiver for Prescription Drug Benefits for Underserved Populations

The Massachusetts Legislature has required the Division of Medical Assistance, the Commonwealth's Medicaid agency, to seek a Section 1115 Research and Demonstration waiver to provide prescription drug benefits to elderly individual with incomes at or below 188% FPL. This Demonstration waiver would be separate from the Commonwealth's current Section 1115 Research and Demonstration waiver, under which the MassHealth program operates. Under the Pharmacy Demonstration waiver, the Commonwealth would evaluate and quantify the cost of providing outpatient prescription drug coverage and the assumed decrease in need for reliance on publicly-funded health care programs for the target population. The results of the demonstration project could provide valuable data to support the development of a broad-based outpatient prescription drug insurance program for Medicare beneficiaries.

The Pharmacy Waiver would apply specifically to elderly individuals with incomes at or below 188% FPL. Although there are no income limits for participation by the elderly in the Prescription Advantage program, the total population that can be served by the Commonwealth currently is limited by the amount appropriated by the state legislature. While state funds are expected to meet program needs, this will not necessarily continue in subsequent fiscal years due to the growing cost of health care and particularly prescription drugs. The availability of federal funds through a new 1115 Demonstration waiver would help ensure that all elderly and qualified disabled individuals whose income is at or below 188% FPL will be served by the program into the future. The Commonwealth would continue to offer prescription drug insurance coverage to elders whose incomes are over 188% FPL.

Providing access to prescription drug coverage to the Pharmacy Waiver population will provide the following benefits:

- Help to preserve the health of the low-income elderly population by providing access to essential prescription drugs, thereby reducing the number of individuals who enter nursing homes

- Reduce the rate and speed at which elders "spend down" and become entitled to all benefits available under the Medicaid program

- Decrease federal Medicare expenditures by providing a primary care benefit that will deter use of more expensive medical services by promoting the appropriate use of outpatient prescription drugs

- Allow for the analysis of a publicly administered prescription drug insurance plan in order to inform the creation of a national prescription drug benefit.

B. Brief History of Prescription Drug Assistance Programs in Massachusetts

The Pharmacy Program (originally the Senior Pharmacy Program) was enacted in 1996 under the Improved Access to Health Care Act, in order to provide limited pharmacy benefits to Massachusetts' elders age 65 and over with incomes at or below 133% FPL, who did not have any form of prescription drug coverage. The program was funded by the state through cigarette tax revenues. Elder Affairs and the Division jointly administered the program. The Pharmacy Program originally provided benefits up to $500 per year to pay for maintenance drugs (for chronic diseases), as well as for insulin and disposable insulin needles. A $15 enrollment fee was automatically deducted from the benefit. At the point of purchase, enrollees made $3 co-payments for generic and $10 co-payments for brand-name drugs. Several changes were made to the Pharmacy Program prior to the enactment of the Prescription Advantage Plan in order to better serve qualified Massachusetts residents. These changes included an increase in the maximum benefit provided per year, an increase in the types of prescription drugs covered under the Program and expanding the Program to allow for enrollment of seniors who had other prescription drug coverage available.

During the summer of 1999, the state Legislature created a separate, one-year catastrophic drug benefit program – The Pharmacy Program *Plus*. The Pharmacy Program *Plus* was created for elders and younger people with disabilities whose gross annual household income was at or below 500% FPL and who experienced catastrophic prescription drug expenses relative to their incomes. The Pharmacy Plus members were required to have spent at least 10% of their gross monthly household income on prescription drugs (including Medicare HMO or The Pharmacy Program benefit payments) in 3 of the 6 months prior to submitting an application. Their continuing prescription drug costs had to exceed 5% of their gross quarterly household income while participating in the program. The Pharmacy Program *Plus* was legislatively authorized to operate from January 1, 2000 though December 31, 2000. A budget of $20 million was allocated for this program.

During the summer of 2000, the legislation authorizing Prescription Advantage was signed into law. Implemented on April 1, 2001, Prescription Advantage replaced both the Pharmacy Program and the Pharmacy Program Plus. Prescription Advantage was created to provide prescription drug insurance coverage to all Massachusetts elders age 65 and over, and to certain younger, low-income individuals with disabilities. Prescription Advantage has an extensive formulary, no income restrictions for people age 65 or older, and is structured like an insurance model. The Plan provides pharmacy benefits only after the members exhaust any other source of prescription drug coverage.

III. Proposed Pharmacy Waiver Program Design

This proposed Pharmacy 1115 Waiver Demonstration program would provide prescription drug coverage to a subset of the population currently served by the state sponsored Prescription Advantage Plan described in Section II. Specifically, the Pharmacy Waiver eligible population would consist of Massachusetts' residents with incomes at or below 188% FPL who are not eligible for MassHealth and who are age 65 or over. The Pharmacy Waiver would provide prescription drug coverage only after members exhaust any other source of prescription drug coverage. All members would pay co-payments.

A. Covered Benefits

The Pharmacy Waiver program's pharmacy benefit would be extensive and include prescription drugs covered under Medicaid. The formulary (the list of drugs available to members) would be broad, covering all or most FDA approved drugs, and would be developed, reviewed and approved by a panel of physicians and pharmacists. The exact drugs within the formulary may be modified as additional or alternative benefit management strategies are considered and implemented for the program. The drugs on the formulary would be categorized into three levels; generic, brand-name and additional brand-name drugs. Generic drugs would have the lowest co-payment and additional brand-name drugs would have the highest co-payments. Both retail and mail order options would be available to members.

Members would not be prohibited from joining or maintaining other prescription drug coverage. The Pharmacy Waiver could serve either as a members' primary prescription drug coverage or as a supplement to their primary source of prescription drug coverage. However, the Pharmacy Waiver program would be the payer of last resort. As such, members must exhaust any other prescription drug coverage they may have before the Pharmacy Waiver pays any benefits.

B. Rate Structure & Cost Sharing

- **Premiums and Deductibles**
  Pharmacy Waiver eligible members may pay premiums and deductibles.

- **Co-Payments: Out-of-Pocket Expenses**
  All members would pay co-payments at the point of service. Co-payment amounts would depend on which tier the drug falls within.
  Generally, the co-payments would be divided into three categories:
  - Level 1: generic drugs which are the least costly to members;
  - Level 2: brand-name drugs that have been chosen for their therapeutic effectiveness and cost and are less expensive than Level 3;
  - Level 3: additional brand-name drugs whose co-payments can equal up to 50% of the drug's price.

The structuring of these co-payments may be modified as additional or alternative benefit management strategies are considered and implemented for the program.

- **Annual Out-of-Pocket Spending Limit**
  All members served under the Pharmacy Waiver would have a pre-determined annual out-of-pocket spending limit. At this time, the annual out of pocket spending limit is a follows: For single members, the limit is $2,000 or 10% of gross annual household income, whichever is less. Married residents whose spouse is also receiving benefits have a combined annual out-of-pocket spending limit of $3,000, or 10% of their household income, whichever is less. Once the out-of-pocket spending limit is reached in co-payments, the plan would cover the full cost of prescriptions until a new plan year begins. Out-of-pocket spending limits may be adjusted annually.

C. Pharmacy Waiver Eligibility Requirements

To be eligible services under the Pharmacy Waiver program, individuals must meet the following eligibility requirement:

- Must be a resident of Massachusetts;
- Must not be eligible for MassHealth (Medicaid);
- Must have a gross annual household income of not more than 188% FPL
- Must be age 65 or older

D. Application Process for Pharmacy Waiver Benefits

The application process would include the following components:

- Elder Affairs would process applications to determine eligibility for both the non-waiver population and the waiver population.

- Applicants would be screened to determine if they are eligible for coverage under the waiver program and reviewed for eligibility for all MassHealth (Medicaid) programs.

- Applications would be accepted by mail and, in the future, applications may be accepted over the Internet or by other appropriate means.

- Upon enrollment, waiver program recipients would receive an identification card specific to the Pharmacy Waiver, distinct from a MassHealth card, and other information pertinent to membership in the Pharmacy Waiver.

E. Redetermination of Membership

An annual member re-determination would be conducted for the purpose of reviewing and confirming a member's eligibility for the Pharmacy Waiver program and screening for potential eligibility for MassHealth.

F. Enrollment Periods

Elder Affairs would develop and implement a yearly open-enrollment period.

G. Coordination with MassHealth Programs

The following are stipulations regarding coordination between the MassHealth program and the Pharmacy Waiver program:

- As stated previously, applicants would be screened for eligibility for other MassHealth programs.

- A process to perform an electronic tape match would be implemented to determine if potential, or existing, members are on MassHealth. If the applicant or member is determined to be on MassHealth, that applicant would be determined not eligible for the Pharmacy Waiver. Members would be notified in advance of these actions and referred to MassHealth.

H. Coordination with Commercial Insurance Plans

Applicants would be required to report any other prescription drug coverage they may have in order to ensure that the Pharmacy Waiver program is payer of last resort. The information would be maintained on the administering agency's database and updated through a monthly health insurance coverage and eligibility tape-match with other health plan information files, as well as an annual re-determination process. Pharmacies and members would be alerted that the Pharmacy Waiver program would pay the cost of the prescription drugs only after the member has exhausted their other source of drug coverage.

I. Benefit Management Strategies

Because individuals often see multiple providers for a variety of conditions, some effective management tools are crucial to improving the primary care they receive and for keeping elders out of hospitals or other institutional settings. The Commonwealth presently contracts with a private pharmacy benefits manager to conduct benefit management for Prescription Advantage. The following benefit management strategies are currently employed and would be employed for the Pharmacy Waiver. DMA and Elder Affairs will also pool resources to review and evaluate other possible enhancements to manage these benefits in a cost-effective manner.

Under the Pharmacy Waiver, DMA and Elder Affairs will work together to leverage resources available to the Commonwealth in order to administer pharmacy services through Prescription Advantage for the Pharmacy Waiver population in the most efficient

and effective manner possible. The Commonwealth will examine a number of alternatives, including the current pharmacy benefit management tools, in order to enhance the management of such benefits. The following benefit management strategies are currently employed and these or similar strategies will be employed for the Pharmacy Waiver.

- **Performance Drug List (PDL)**
  This list of drugs represents preferred choices for members within select, highly utilized therapeutic categories. It is a subset of the formulary with drugs in over 31 select therapeutic classes. The generic and preferred brand drugs represented are clinically approved and cost effective. The PDL list helps physicians identify products that help maximize clinical results and economic value. The PDL is administered as a preferred drug list. The use of drugs not on the list is discouraged but members can access them on the Plan's third tier. The Plan obtains the advice of external clinical experts for the development and review of the PDL.

- **Concurrent Drug Utilization Review (DUR)**
  Drug Utilization Review (DUR) tools help to maintain clinical quality and manage costs. The DUR tools used currently by the Prescription Advantage Plan include retrospective, concurrent, and prospective reviews that positively influence prescribing trends and help optimize prescription drug therapy through physician and pharmacist education before, during, and after drug therapy is initiated.

  The DUR program will perform real-time, online editing of drug therapy prior to the time the prescription is dispensed, sending alert messages and warnings to the pharmacy when potential drug conflicts are identified. In addition to identifying potential adverse drug interactions and/or compliance problems, online messages will signal the pharmacist to check for other potential problems such as early refills, excessive drug use, potential drug conflicts, and therapeutic duplications.

- **Formulary Compliance**
  A formulary compliance program will work in conjunction with the PDL and to help lower drug costs by promoting preferred medications. The program is intended to accomplish the following:
  - Promote the use of preferred drugs over non-preferred drugs;
  - Through an Online message, notify pharmacist of intervention opportunity at the point-of-service;
  - Require Physician and member approval change to a preferred drug.

J. Collaborative Purchasing Strategies

DMA and Elder Affairs will collaborate with other state entities to identify cost effective strategies for purchasing prescription drugs jointly for individuals served by each

agency's members. Although this collaboration is still in the preliminary stages, implementation of viable strategies may be undertaken during the waiver period.

IV. Access to Primary Care for Uninsured Members

As part of the Pharmacy Waiver, the Commonwealth would promote access to existing primary health care services for those served by the waiver who do not have health insurance coverage for primary care services and are not eligible for MassHealth. To do this, the administering agency would refer such applicants to health care services that are currently available to low-income uninsured populations. These activities will help promote improved health outcomes for those served by the Pharmacy Waiver by ensuring that they are aware of their access to primary health care treatment.

Uninsured Plan Members and Applicants

During the application process, the administering agency will identify, through self-reporting, individuals who do not have health insurance. Currently, less than 5% of Prescription Advantage members do not have other health insurance, such as Medicare. Additionally, applicants will be screened for potential eligibility for MassHealth. Applicants who indicate on their application that they do not have health insurance coverage will be sent an informational package on available primary care. The informational package will include:

- A narrative on the importance and impact of comprehensive primary health insurance coverage on a person's health, in concert with prescription drug coverage;

- A description of the availability of affordable primary health care for uninsured low-income individuals through the Uncompensated Care Pool (described below).

Additionally, the administering agency will develop a referral system to provide ongoing referrals to the services provided through the Uncompensated Care Pool to uninsured individuals served by the Pharmacy Waiver. A tracking system for those referrals will be established.

The Uncompensated Care Pool

The Massachusetts legislature established the Pool in 1985 as a financing mechanism to distribute the burden of bad debt and providing free care (together known as uncompensated care) more equitably among acute care hospitals. The Pool was intended to help pay for the cost of providing care to the uninsured and underinsured, and also to eliminate financial disincentives that a hospital might have to provide such care. The Pool's free care provider network was later expanded to include services provided at community health centers in the Commonwealth. The number of health care providers receiving payments from the Pool in fiscal year 2000 was 68 acute hospitals and 31 community health centers. The Pool pays hospitals and community health centers for medically necessary services provided to:

1. Patients deemed financially unable to pay, in whole or in part, for their care;

2. Uninsured patients who receive emergency care for which the costs have not been collected after reasonable efforts; or,

3. Patients in situations of medical hardship where major expenditures for health care have been depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services will be unpaid.

Individuals with family incomes at or below 200% of the federal poverty level (FPL) are eligible for full free care.

Coordination with the Uncompensated Care Pool

The agency administering the Pharmacy Waiver will coordinate with the Uncompensated Care Pool's health care provider network to inform them that the Plan will generate referrals to them. The agency will mail written information to community health centers about the Pharmacy Waiver's role in identifying and referring uninsured individuals. The mailing will describe benefits services provided under the Pharmacy Waiver.

V. Pharmacy Waiver Implementation and Administration

A. Administering Agency

Elder Affairs would administer the Pharmacy Waiver program, as a part of Prescription Advantage through an interagency agreement with the DMA, the single state Medicaid agency. Elder Affairs currently contracts with a private pharmacy benefits manager, which administers drug benefits and processes the claims for the pharmacy program. Elder Affairs also contracts with the University of Massachusetts Medical School to perform the customer service and enrollment aspects of the program. DMA and Elder Affairs would work together to ensure the Pharmacy waiver is implemented in a manner that leverages the most efficient purchasing mechanisms for prescription drugs available to the Commonwealth.

B. Financing

Services provided under the Pharmacy Waiver would be funded jointly through State funds and matching federal funds. Prescription Advantage would continue to provide access to prescription drug insurance coverage at full state cost to Massachusetts' residents 65 and older and qualified disabled individuals with incomes above 188% of the FPL with State funds. Massachusetts is currently requesting through a separate process that the services provided by Prescription Advantage to qualified disabled individuals with incomes below 188% of the FPL be covered through an amendment to the Commonwealth's existing comprehensive 1115 waiver.

Additional program revenue or cost offsets for services provided under the Pharmacy Waiver would be derived from the enrollee cost-sharing components mentioned previously. If the final waiver terms and conditions approved by CMS for this Pharmacy Waiver would meet the criteria for the federal drug rebate program (under 42U.S.C. 1396r-8), then the Commonwealth would seek such rebates under this waiver.

C. Implementation Schedule

The Commonwealth requests the Pharmacy Waiver program for a five-year period and is aggressively pursing an implementation date for the Waiver of October 1, 2002.

D. Early Termination of the Pharmacy Waiver Program

Massachusetts reserves the right to cap the number members receiving Prescription Advantage services with federal matching funds under this waiver if such an action is necessary to allow the waiver to be budget neutral. Additionally, Massachusetts reserves the right to end this Pharmacy Waiver should actual experience show that it is not budget neutral even if federal matching funds on the number of members receiving services through Prescription Advantage are capped. Further, Massachusetts may amend or terminate this program should any federal program provide access to prescription drugs

for all or part of the waiver population. In the event that the waiver program is terminated due to the creation of a federal program, Massachusetts' residents should not be restricted from participation in any such federal program.

VI. Waivers Requested

This demonstration program requires waivers from provisions of Title XIX of the Social Security Act and federal regulations promulgated thereunder. This section does not address our proposal comprehensively, but instead speaks to those areas that the Commonwealth has determined require waivers. Section 1115(a)(2) permits Massachusetts to regard as expenditures under the State plan costs of the demonstration project that would not otherwise receive a federal match under section 1903 of the Social Security Act. This provision allows the Secretary of the Department of Health and Human Services (Secretary) to waive existing program restrictions and provide expanded eligibility and/or services to individuals not otherwise covered by Medicaid.

Massachusetts requests that, under the authority of Section 1115(a)(2), expenditures for the items identified below (which are not otherwise included as expenditures under Section 1903) be regarded as expenditures under Massachusetts' Medicaid State Plan:

- Expenditures to provide and receive comprehensive pharmacy benefits to individuals whose income is at or below 188 percent of the FPL, who are seniors age 65 and older
- Administrative expenditures for demonstration participants including but not limited to collecting program participants' fees, enrolling pharmacies, producing and distributing enrollment cards to program participants, responding to client inquiries, collecting third-party insurance information and evaluation and monitoring of this demonstration waiver, including its impact on federal Medicare expenditures.

If the Secretary deems that it must grant waivers of the following provisions in order to approve a demonstration project as described above under Section 1115 (a)(2) of the Social Security Act, the Commonwealth requests that it do so:

- Eligibility- Income. Sections 1902(l), 1903(f) of the Social Security Act and Sections 435.100 et seq. of Title 42 of the Code of Federal Regulations (CFR). These sections prohibit Federal Financial Participation (FFP) to states that implement income eligibility standards in excess of the stated maximums. Massachusetts seeks to expand eligibility for pharmaceuticals to non-categorical individuals with incomes at or below 188 percent of the FPL.

- Eligibility - Resources. Sections 1902(a)(17), 1902(a)(10)(A)(ii)(I) and (II) of the Social Security Act and 42 CFR Part 435, Subparts G, H, and I. These sections establish standards for taking into account income or resources of individuals who are not receiving assistance under

Temporary Assistance to Needy Families (TANF) or Supplemental Security Income (SSI). All TANF and SSI recipients are entitled to Massachusetts Medicaid benefits. People who are ineligible for TANF or SSI benefits will be eligible for this demonstration pharmacy program if they meet age and income requirements, however, there will not be an asset test applied to demonstration population. Massachusetts seeks to use different standards for taking into account resources in determining eligibility for this demonstration project.

- Comparability. Section 1902(a)(10)(B) of the Social Security Act and 42 CFR 440.230 through 440.250. These sections require the amount, duration, and scope of services be equally available to all recipients within an eligibility category and be equally available to all categorically eligible and medically needy recipients. Massachusetts seeks to offer a comprehensive drug benefit to the proposed expanded population.

- Copayments. Section 1916(b)(3), 1616(e), and 1916(e) of the Social Security Act, and 42 CFR 447.54. Section 1916(b)(3) requires that copayments be nominal in amount and identical among all Medicaid recipients. 42 CFR 447.54 lists the maximum allowable charges for copayments. Massachusetts seeks to establish copayments that vary from the general Medicaid populations and to establish copayment amounts that exceed the maximum allowable amount, but include an out of pocket maximum of $2000 or 10 percent of the member's income, whichever is less. Section 1916(e) requires that no provider participating under the state plan deny services to an eligible individual for inability to pay the cost-sharing amount. Massachusetts seeks not to require a retail pharmacy to dispense an outpatient prescription upon the failure of an enrollee to make the required copayment.

- Retrospective Benefits. Section 1902(a)(34) of the Social Security Act and 42 CFR 435.914 require a State to provide medical assistance retroactively for up to three months prior to the date of application in certain circumstances. Massachusetts seeks to establish the effective date for demonstration participants as the date of enrollment as determined in accordance with enrollment process outlined earlier in this document.

- Administration. Section 1902(a)(5) of the Social Security Act and 42 CFR 431.10. These sections prohibit the State from contracting with a private contractor to make eligibility determinations for Medicaid. Massachusetts intends to use a pharmacy program enrollment contractor to process applications and determine eligibility.

Massachusetts requests the right to seek other waivers if the Secretary or the Commonwealth determines subsequently that additional waivers are needed to implement the proposed pharmacy program.

Section VII: Budget Neutrality

Overview Description of Model:

Pursuant to Section 1115 of the Social Security Act, a state must demonstrate that a proposed waiver program will not cause federal expenditures to increase beyond what they would have been under traditional Medicaid rules over the five-year waiver period. For pharmacy waivers, CMS has created a draft pharmacy template that includes a specific formula that must be used to determine budget neutrality. Under this formula, a state must calculate an aggregate cap that limits the amount a state may spend on its 65 and older population in order to receive a pharmacy waiver. This model creates great risks for states as it seemingly forces a state to accept all the risk for increased costs to its program that would happen with or without a waiver but are not accounted for within the aggregate cap formula.

While the Commonwealth is not using the precise formulas found in the draft template to calculate a budget neutrality cap, we are attempting to incorporate the basic structure found in the draft pharmacy template by using as the budget neutrality cap an aggregate cap that will not fluctuate with actual changes in caseload. To calculate this "without waiver" aggregate cap, the Commonwealth will project both caseload and per member per month (PMPM) spending growth for populations listed below. The caseload for each population will then be multiplied by the relevant PMPM, and the totals will be summed for a total aggregate cap. To demonstrate budget neutrality, this calculated aggregate cap will then be compared to the actual expenditures for the population.

The Commonwealth expects to be able to achieve budget neutrality through this waiver as access to pharmaceuticals increases the health of the target population, lessening the demand on traditional Medicaid covered services. Specifically, the Commonwealth expects the number of people who either become nursing home certifiable or spend down into the community-based program to decrease as a result of the health benefits provided by pharmaceuticals. The Commonwealth also expects there to be a significant reduction of costs to the Federal Medicare program. These potential Medicare savings are described in detail below.

Caseload Description:

Pharmacy Benefits Population: These are individuals who are sixty-five and older who are not eligible for any other Medicaid category. Without the waiver, the Commonwealth could provide benefits to this population through a state plan under an expansion allowable under section 1902(R)(2) of the Social Security Act. Under the waiver, the Commonwealth intends to provide pharmacy benefits as described in other sections of this document. Since almost all (95%) of this population has access to other benefits under Medicare, by providing prescription benefits the Commonwealth is helping this population access comprehensive health care.

Nursing Home Population (65+): These are MassHealth eligibles who are sixty-five and over and are in nursing home care. The Commonwealth expects fewer individuals to become nursing home certifiable because of access to pharmaceuticals under this pharmacy waiver program.

Community Population (65+): These are individuals who are sixty-five and over and are not in institutions. These individuals become eligible for MassHealth either through meeting income and asset standards or through the "spend down" process. The Commonwealth expects fewer individuals to "spend down" onto MassHealth because of access to pharmaceuticals under this waiver program.

Caseload Projections:

Pharmacy Benefits Population: Because this population is relatively new, it is not possible to project population growth using historical data. Both "without waiver" and "with waiver" caseload estimates for this population include a "ramp" up period through FY03, and then level out to an approximate 5% growth rate.

Nursing Home Population (65+): As stated above, the nursing home certifiable population includes MassHealth enrollees who are in an institution. "Without waiver" caseload for this population was estimated by trending enrollment from the base year by an average of 0.8% over the course of the waiver. Caseload projections are lower in FY2003 to FY2005, when the projected Massachusetts elderly population is not growing, and are higher in FY2006 and FY2007, when growth in the elderly population is expected to resume.

The Commonwealth is projecting increased caseload despite the fact that the total 65 and older population is not growing because we anticipate a higher penetration rate as the proportion of the elderly population who are 85 and older increases. Since those who are older are more likely both to be poor and to have higher healthcare needs, the increase in this subset of over 65 population means that a larger proportion of the elderly will likely become eligible for MassHealth. While many of those who become eligible will access community-based services, the Commonwealth expects a small proportion of the newly eligible population to receive nursing home care.

As shown in Table 1, according to state level projections by the U.S. Census Bureau, the number of people over 85 is expected to increase over the waiver period[4].

[4] www.census.gov/population/www/projections/stproj.html

Table 1. Massachusetts Elderly Population

Projected Massachusetts Elderly Population					
	2003	**2004**	**2005**	**2006**	**2007**
65+	1,662,856	1,658,572	1,656,636	1,658,523	1,668,006
85+	255,308	261,084	267,674	274,678	282,059
85+ as Percent of 65+ Population	15.35%	15.74%	16.16%	16.56%	16.91%

Projected Growth in Massachusetts Elderly Population				
	2004	**2005**	**2006**	**2007**
65+	-0.26%	-0.12%	0.11%	0.57%
85+	2.26%	2.52%	2.62%	2.69%

Those who are 85 or older are more likely to have the low incomes that allow them to qualify for Medicaid. According to a Kaiser Family Foundation report on Medicare recipients, who constitute the majority of the elderly, 14% of those who are 85 or older lived at or below the poverty line in 1999, while 9% of those ages 65-74 and 10% of those ages 75-84 had incomes at or below the poverty line during the same time period[5]. The number or people who are poor may increase further as a result of the recent recession. The continuing decline of the stock market will likely have a dramatic impact on those who are retiring in the next few years who are dependent on defined contribution plans, such as 401Ks and IRAs, for their retirement income.

In calculating the "with waiver" caseload for the Nursing Home population, the Commonwealth assumes that access to prescription drugs through the waiver program will improve the health of individuals and therefore reduce the number of people who become sick enough to need nursing home care. In estimating the number of people who will likely be diverted each year, the Commonwealth assumes that the proportion of the nursing home population who will not become eligible for nursing home care because of access to pharmaceuticals will increase each year. The Commonwealth assumes that only 0.25% of the Nursing Home population will be diverted in FY2003, but that this diversion rate will grow to 4.50% by FY2007.

Community Population (65+): The Community "without waiver" caseload is estimated to grow at an average of 4.3% over the course of the waiver. As with the nursing home caseload growth, the Community population caseload is projected to grow more quickly in the out years, as the elderly population in Massachusetts increases. This projected caseload growth is driven both by increases in the 85 and older population and in increases in community based services. Just as the Commonwealth expects the increase

[5] The Henry J. Kaiser Family Foundation Medicare Chart Book, Second Edition, Fall 2001

in the 85 and older population to drive up the penetration rates, we anticipate that the availability of increased community based services to increase the proportion of the 65 and older population who become eligible for MassHealth. Specifically, individuals who qualify for nursing home care but do not want to reside in an institution will be more likely to attempt to get services through MassHealth than if community services were not available. Anticipated improvements in MassHealth community based long-term services are described in detail in the "Cost Drivers" section below.

This population is expected to decrease on the "with waiver" side of the calculation as access to pharmaceuticals prevents the acute care associated with high health care costs which leaves more people "spending down" into the Medicaid program. However, because most of this population will be Medicare eligible and are likely to receive most of their health care services in acute care settings, the Medicare program will realize most of the savings. The change in the rate of spend down, and thus in the number of people entering the Community population, will therefore be limited. For this reason, the Commonwealth assumes that a small proportion of the Community population will be diverted, with diversion rates starting at 0.25% in FY2003 and growing to 2.50% in FY2007.

Table 2. Caseload Projections

Caseload Projections (member months)

Pharmacy Benefit Caseload

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Without Waiver	745,582	782,861	822,004	863,104	906,260
With Waiver	745,582	782,861	822,004	863,104	906,260
Variance	-	-	-	-	-

Nursing Home Caseload

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Without Waiver	432,127	435,368	438,633	443,020	447,450
With Waiver	431,047	424,484	425,474	425,299	427,315
Variance	1,080	10,884	13,159	17,721	20,135

Community Caseload

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Without Waiver	858,022	892,343	928,036	969,798	1,018,288
With Waiver	855,877	883,419	914,116	950,402	992,831
Variance	2,145	8,923	13,921	19,396	25,457

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Total Diverted	3,225	19,808	27,080	37,117	45,592

Without Waiver Percentage Growth Rates

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007

Pharmacy Benefit Caseload	5.00%	5.00%	5.00%	5.00%
Nursing Home Caseload	0.75%	0.75%	1.00%	1.00%
Community Caseload	4.00%	4.00%	4.50%	5.00%

Historical caseload levels can be found in Attachment 2.

Per Member Per Month Projections:

The without waiver PMPM amount is based on a calculated base year PMPM for Medicaid costs for each population which is then trended forward by a projected growth rate over the course of the waiver. The Commonwealth contends that this understates the savings to the federal government because it does not include Medicare savings. Medicare savings are therefore included in a separate line item in the budget neutrality aggregate expenditure cap summary.

Excluded Costs

Budget neutrality costs include all expenditures paid in claims by the Division of Medical Assistance for those who are 65 and older and on the MassHealth caseload. Expenditures for the Home and Community Based Waiver paid for exclusively by the Executive Office of Elder Affairs are not included in the budget neutrality calculation.

Cost Drivers

Throughout the Massachusetts Medicaid program, certain provider types tend to influence the cost growth of the program more than others. In projecting PMPM growth, historical PMPM costs were broken out into components that are relevant to each population to better illustrate why costs are growing for each population. Each cost component is then projected forward, and the results added together to calculate the total projected PMPM for each year. In some cases, the growth rate of the cost component is increased above historical trends if there are reasons to believe that the growth of these components will be higher in the future than they have been in the past. An explanation of how the PMPM components are trended forward is described in each population group section below. Major cost drivers for the Medicaid program are as follows:

Medicaid Pharmacy Costs

Per member expenditures on pharmaceuticals have increased at over 13% annually, on average, since SFY1997 for the Nursing Home population and by over 17% annually, on average, since SFY1997 for the Community population. Since pharmacy expenditures are already a large proportion of spending, accounting for 34% of dollars spent on Community members in SFY2001, continued high rates of growth for pharmacy expenditures are expected to disproportionately drive up the total PMPM cost for the Community population. Additionally, although pharmacy spending is a smaller portion of nursing home spending, the high PMPM growth rate for pharmacy will cause pharmacy costs to have an increasing impact on the PMPM rate for the nursing home population.

The trend in increased drug costs is not specific to MassHealth. Research has shown that pharmaceutical costs are increasing for most health purchasers nationally because of: 1) an increase in the price of existing drugs; 2) an increase in the average number of drugs prescribed for individuals; and 3) a tendency for individuals to be prescribed new, more expensive drugs for similar ailments as these medications become available.[6] Massachusetts' experience is consistent with national trends in the cost and utilization of prescription drugs. Nationally, spending on pharmaceuticals for all payers increased by 84% between 1993 and 1998.[7] The National Pharmaceutical Council reported that between 1994 and 1998 average Medicaid pharmacy costs throughout the nation increased by over 50%.[8] These trends are not expected to abate in coming years.

Nursing Home Services

The Commonwealth will likely need to increase reimbursement rates for nursing homes in the future as the result of provider pressure. As required by law, in July 2002 nursing home rates will be rebased to reflect CY2000 cost data. This increase will accompany a change in the nursing home rate year from January to July. A small rate increase was also established in January 2002. In addition, the Commonwealth expects to enact a substantial rate increase during FY 2003.[9] This rate increase is intended to ensure continuing access to nursing home care. According to data from the Massachusetts Department of Public Health, over 2,800 nursing home beds were closed and not replaced between 1999 and 2001 (Table 3). This is most concerning in rural regions, where nursing home occupancy rates are already as high as 97%.

Table 3. Nursing Facility Bed Closures and Additions, 1999-2001

	1999	2000	2001	Total
Closed Facilities	1,095	1,476	1,320	3,891
Re-Opened Facilities	324	364	369	1,057
Variance	771	1,112	951	2,834

The Commonwealth is especially concerned that the financial difficulties within the nursing home industry may negatively affect quality of care. For example, a nursing shortage is driving up nurses' wages. Nursing homes assert that they do not have the resources necessary to purchase adequate nursing services. Additionally, as buildings age, capital improvements will be necessary.

Because Medicaid is the primary payer for nursing home residents, covering approximately 72% of such residents in 1999, the MassHealth program is in a unique position to bolster nursing home finances in an effort to maintain access to nursing

[6] The Henry J. Kaiser Family Foundation, Prescription Drug Trends: A Chartbook, July 2000.
[7] Barents Group, LLC, "Factors Affecting the Growth of Prescription Drug Expenditures", July 1999.
[8] National Pharmaceutical Council, Pharmaceutical Benefits Under State Medical Assistance Programs, 1999.
[9] The final FY03 state budget contains a substantial rate increase for nursing facilities that includes $70 million for a rebasing of rates based on updated costs (see note above); up to $129.1 million for an enhanced rate; $50 million for one-time rate increases to improve the quality of nursing home staff; and $12 million for one-time enhanced payments to nursing facilities for capital costs.

homes. This is especially true as other payers contribute less to nursing home services. For example, Medicare covered 9% of nursing home stays in both 1995 and 1999. However, nursing home revenues from Medicare dropped from 21% to 16% over the same time period, primarily as a result of the Medicare payment changes associated with the Balanced Budget Act of 1997.

Medicaid payments to nursing homes are expected to continue to increase over the waiver period as a result of the aging population. As stated earlier, the proportion of people in Massachusetts who are 85 or older are expected to increase during the course of the waiver, likely driving up the number of those 85 and older who are on the MassHealth caseload. As the nursing home population ages, they are more likely to need more services. Because nursing home rates are adjusted for acuity, the aging of the Medicaid population will in and of itself drive up nursing home PMPM growth rates.

Community Based Long Term Care Services

A desire to remain in the community rather than in an institutional setting has resulted in increased utilization of community long-term care services that is expected to continue to increase in the future. Community long-term care services include those provided by personal care attendants (PCA), home health agencies, private duty nurses (PDN), adult foster care programs, adult day health programs, day habilitation programs and hospice programs. DMA is currently participating in a state-wide inter-agency effort to enhance existing community based long-term care services. These changes will likely bring about dramatic differences in the services utilized by community-based seniors over the waiver period.

The Commonwealth is planning on making major revisions to its community based long-term care programs, in part as a result of the Supreme Court's decision in Olmstead v. Zimring. In June 1999, the Supreme Court ruled that states are required to provide community-based services for people with disabilities when the state's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others. Because many people who are sixty-five or older are disabled, as that term is used under the Americans with Disabilities Act, changes made as a result of the Olmstead decision will influence costs to the elderly who receive community based long term care services.

The Commonwealth is currently in the process of planning sustainable changes that will help the state comply with the spirit of Olmstead. Although these plans are still being developed, Massachusetts will be taking specific, concrete steps towards enhancing community based long term care services starting in FY03. Specific activities fall within the general categories of education and outreach, identification of individuals, assessment and planning for individuals and the system, and service coordination. These activities will touch on and enhance every aspect of community based long term care provided to the Medicaid population.

A second factor that will likely increase community long term care spending is an eligibility change as result of state litigation known as the Hermanson lawsuit. Prior to settlement of Hermanson, the Commonwealth applied a recurring deductible to disabled persons age sixty-five and older under the traditional Medicaid program, versus the application of a one-time deductible to non-working disabled persons under age sixty-five under the demonstration project. The plaintiffs alleged that disabled persons who met the one-time deductible under the demonstration project, and thus lived at home with PCA services while under age sixty-five, could not meet the recurring deductible applied under the traditional Medicaid program when they turned sixty-five. The Hermanson lawsuit alleged that the different eligibility rules for (1) the disabled under-65 and (2) the disabled 65-and-over violated the Americans with Disabilities Act. To address these concerns the Division obtained federal approval to increase the unearned income disregard for seniors in need of PCA services. This will increase the ability of seniors to meet their deductible requirement and allow those currently meeting one to do so more quickly.[10]

Community-based long-term care expansions may also drive up caseload as a result of the "Community Choices" initiative, which is part of the final FY03 budget. Through this initiative, the availability of community services will be increased for the purpose of delaying or preventing imminent nursing home admission. While many of the services provided through this initiative will be paid for through the Office of Elder Affairs, and are therefore outside the scope of this budget neutrality projection, the initiative may encourage more individuals to seek community care, driving up the MassHealth Community caseload.

Base Year

This budget neutrality model uses SFY01 as a base year because this is the most recent complete year. Unless stated otherwise, the base year PMPM is the actual PMPM for the population in that year, based on MassHealth claims. Below is an explanation, by population, of how each PMPM growth rate is calculated. Detailed projections are shown in Attachments 2, 3 and 4.

Population Specific PMPM Trends

Pharmacy Benefits Population: The without waiver PMPM cost growth rate for this population is calculated based on the assumption that the Commonwealth could expand benefits to this population without a waiver using section1902(R)(2) of the Social Security Act. The PMPM amount is matched to the Community population PMPM. An explanation of how the PMPM trend rate is calculated is described in the Community population section below.

With waiver PMPM projected expenditures are based on the scope of services described in this waiver application. Because of the lack of historical data used in projecting forward costs, the "with waiver" PMPM growth rate for this program is calculated by assuming that PMPM growth will be slightly lower than that found in Medicaid

[10] Members with incomes over 133% of the FPL would have to spend down only to 133% ($982) rather than to the medically needy monthly income standard of $522.

Community population prescription spending. This assumption is based on the expectation that this program will attract a population that is, on average, somewhat healthier than the Medicaid Community population has been historically. To incorporate expected savings from planned increase in member co-payment rates, the PMPM growth rates are further decreased in future years.

Nursing Home Population (65+): The base year (SFY01) for the Nursing Home was calculated based on the actual SFY01 spending, and then increased to reflect planned one time increases to nursing facility rates[11]. The growth rate for the nursing home PMPM amount is then calculated by projecting forward historical average claims data. To do this, historical PMPMs were broken out into the major spending service components for this population group, namely nursing homes, community long term care, pharmacy, and all other expenditures. Each component was then trended forward and the results were added together to determine the total projected PMPM for this population for each wavier year (See Attachment 3).

Two adjustments were made to these historical averages. For community long-term care services, the average PMPM growth rate was increase by 5% to reflect expected changes in community-based services described early in this document. Additionally, the Commonwealth adjusted the "all other services" component based on the belief that the decreases in spending in these services in SFY1998 and SFY1999 will not be seen in the future. Rather, the Commonwealth believes that the higher growth rates seen in SFY2000 and SFY 2001 will likely continue. The Commonwealth therefore used an average of the growth rate between SFY1999 and SFY2001 to project PMPM growth for these services.

Community Population (65+): As with nursing homes, the estimate of PMPM trends for the Community population is calculated by breaking the PMPM into service components of nursing homes, community long term care, pharmacy, and all other expenditures. These components are trended forward independently and then added together for a total PMPM for this population. As with the nursing home population, the 5% increase is added to the average growth rate for community long term care services (See Attachment 4).

Table 4. Per Member Per Month (PMPM) Projections

Population Groups	2003	2004	2005	2006	2007
Nursing Home Population	$4,284.35	$4,514.55	$4,763.62	$5,035.41	$5,335.23
Community Population / 1902(R)(2) Population	$539.20	$615.37	$704.02	$807.33	$927.91

[11] The amount added to the base is derived from a $261M increase included in Massachusetts FY2003 General Appropriation Act. As 89% of all nursing home costs are paid for MassHealth members who are 65 or older, 89% of the $261M is appropriated to the nursing home base. See footnote 6.

Federal Savings Through Medicare

Although the Commonwealth believes that it can achieve budget neutrality without including expected Medicare cost reduction, we also believe that it would be appropriate to include all federally funded health care costs relevant to this population. Section 1115 of the Social Security Act requires that 1115 waiver programs cost the federal government no more than it would have spent had the program been operating under traditional rules. Historically, Medicaid 1115 waivers have demonstrated budget neutrality by showing that the federal government will not spend any more through the Medicaid program under the 1115 waiver than it would have without the waiver. This is generally appropriate because most of the federal governments' health care expenditures for covered members will be found in the Medicaid program. However, exceptions have been made in the past when it has been appropriate to include federal savings for other programs. Specifically, states previously were allowed to expand Transitional Medical Assistance (TMA) programs through federal waivers, meeting budget neutrality requirements by offsetting increased federal Medicaid costs with decreased federal AFDC costs[12]. Because the Commonwealth believes that there will be federal savings to the Medicare program, it would be appropriate to include Medicare costs in the budget neutrality scenario.

An estimated 95% of the beneficiaries of this waiver will receive health care services subsidized by the federal government through both the Medicare program and the Medicaid program. Because health care services for members served will be spread across the two programs, savings from efficient and effective use of prescription drug services may be seen in both programs. For this reason, the Commonwealth is requesting to include Medicare expenditures in the budget neutrality calculation for this waiver[13].

By providing access to pharmaceutical drugs, the state is providing dually eligible individuals with a benefit that will not only increase their health status but will likely decrease the amount that the federal government will have to pay for acute Medicare services for covered individuals. According to a report by the Henry J. Kaiser Family Foundation[14], Medicare beneficiaries without drug coverage fill over one-third fewer prescriptions than those with a similar health status who have drug coverage. In a testimony before Congress, Patricia Neuman of the Kaiser Family Foundation reported that such underutilization of drugs "potentially increases costs to the [health care] system in terms of avoidable emergency room and hospital admissions, physician visits and nursing home stays."[15]

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[12] Transitional Medical Assistance (TMA): Medicaid Issue Update, Kaiser Commission on Medicaid and the Uninsured, June 2002

[13] At the very least, the Commonwealth should be able to monitor savings within the Medicare program and be able to use such savings should the waiver not be budget neutral without those savings.

[14] The Henry J. Kaiser Family Foundation Medicare Chart Book, Second Edition, Fall 2001, The Henry J. Kaiser Family Foundation

[15] "Improving Prescription Drug Coverage: Opportunities and Challenges for Reform," Patricia Neuman, Sc.D. , Vice President and Director, Medicare Policy Project, The Henry J. Kaiser Family Foundation

Data from Massachusetts' Program of All-Inclusive Care for the Elderly (PACE) program[16] shows that dual eligibles receiving comprehensive health services, including pharmaceuticals, had lower rates of hospitalization. The PACE program has shown significant benefits for its members. PACE programs have improved coordination, offered a greater range of services and supports, and reduced both hospitalizations and nursing home placements. A study performed by the Massachusetts Division of Health Care Finance and Policy found that PACE enrollees had 50% fewer hospitalizations that could have been prevented with proper chronic disease management than a comparable population enrolled in the state's 1915(c) home and community based waiver program.

In providing access to pharmaceuticals, then, this waiver is expected to reduce demand on acute services that are paid for by the federal government through the Medicare program. Table 5 shows the projected cost of providing Medicare services to individuals who will receive Prescription Advantage pharmacy services under the waiver. These Medicare expenditures are included in our proposed aggregate cap in a separate line (see Attachment 1).

Table 5. Waiver Related Medicare Cost Projections

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Pharmacy Benefit Caseload	745,582	782,861	822,004	863,104	906,260
Percentage of Pharmacy Benefit with Medicare	95%	95%	95%	95%	95%
Pharmacy Caseload with Medicare	708,303	743,718	780,904	819,949	860,947
Medicare PMPM	$659	$699	$746	$793	$842
PMPM Growth Rates	4.00%	6.20%	6.60%	6.30%	6.20%
Total Projected WOW Medicare Cost	**$ 466,531,866**	**$ 520,229,684**	**$ 582,293,085**	**$ 649,926,427**	**$ 724,732,958**

The Commonwealth does not have ready access to Medicare per member per month expenditure data. PMPM expenditures are therefore derived from recent reports from the Kaiser Family Foundation[17]. Additionally, because Medicare is not run by the state, we are reluctant to claim an ability to project Medicare costs. We therefore used national per member per year projections based on the 2001 Reports of the Medicare Board of Trustees provided in the National Health Expenditure Projections found on CMS'

[16] The PACE program (Program of All-Inclusive Care for the Elderly) is designed to address the needs of frail seniors living in the community. In 1990, Massachusetts established one of the first federal demonstration sites for the Program of All-Inclusive Care for the Elderly (PACE). Based on the On-Lok program in San Francisco, PACE is available to elders who are eligible for both Medicare and Medicaid, and is administered through a partnership between the PACE providers, CMS, and DMA. PACE programs focus on frail elders at risk for institutionalization (persons who meet the clinical standards for nursing facilities). PACE offers a coordinated and comprehensive range of medical care and community supports and helps members to stay in the community as long as it is a safe and appropriate choice.

[17] "Medicare Chart Book," Kaiser Family Foundation, Second Edition, Fall, 2001

website[18]. Caseload for this population is calculated as being 95% of the caseload for Prescription Advantage members who are eligible for this waiver.

Because the Commonwealth does not have ready access to detailed Medicare data on this population, we have an estimated projection of Medicare expenditures. Future Medicare expenditures may be influenced by changes in federal policy as well as by Prescription Advantage. The Commonwealth cannot precisely calculate savings to the Medicare program at this time.

The Commonwealth contends that Medicare spending for Massachusetts' residents will decrease over the course of this waiver as a result of Prescription Advantage. As stated in the Evaluation section of this waiver (Section 8), the Commonwealth requests that at the very least we obtain access to detailed Medicare data relevant to this waiver.

[18] http://www.hcfa.gov/stats/NHE-Proj/proj2001/tables/t4.htm

VIII. Program Evaluation and Monitoring

The Commonwealth maintains that, by providing access to prescription drugs for this group, individuals covered under the Pharmacy Waiver will acquire a basic primary care benefit that will enable them to maintain their health and thus delay their eventual enrollment in Medicaid. As will be discussed in more detail below, using the current data as a baseline, the Commonwealth will partially measure the effectiveness of this waiver by the overall decrease in Medicaid eligibility. This decrease will occur because early access to pharmacy benefits may prevent illness that can require more expensive treatments such as inpatient hospital stays and nursing home care. Avoiding the need for more expensive treatment will both improve the quality of life for individuals covered under the Pharmacy Waiver and prevent such individuals from "spending down" to become eligible for Medicaid services.

To measure the full effect of the Pharmacy Waiver, it is important to measure not only the resultant decrease in Medicaid spending but also the resultant decrease in Medicare spending. Because most of the population covered under this waiver will also be eligible for Medicare benefits, the potential savings to Medicare could be substantial. This is especially true as Medicare covers many of the acute care services for which use may decline as a result of appropriate access to pharmacy benefits. The Commonwealth proposes to obtain current Medicare utilization data to use as a baseline, and subsequent data with which to measure its cost-effectiveness. As this is data not readily available, the Commonwealth needs to partner with the Centers for Medicare and Medicaid Services (CMS) to obtain this data on an ongoing basis.

Massachusetts' proposed Pharmacy Waiver program offers CMS the opportunity to evaluate the cost-savings for both Medicaid and Medicare, and it could serve as a model for the development of a broad-based outpatient prescription drug insurance program for Medicare beneficiaries. As such, extensive quantitative and qualitative monitoring is warranted to identify the outcomes and implications associated with its implementation. Massachusetts will address the outcomes of its program by exploring the following research questions:

A. *Health*: Does the waiver program, through expanded access to a comprehensive pharmacy benefit and sophisticated benefit management tools, reduce the utilization of acute health care services such as inpatient hospital services and nursing home services by the low-income elderly population?

B. *Resources*: Is there a reduction in the utilization of and dollars spent on non-pharmacy services for program participants as a result of the expanded access to necessary medications?

C. *Health Policy*: Are the cost savings associated with this program sufficient to influence larger Medicaid or Medicare policy and planning?

The following sections present a framework that may be used by evaluators to analyze the outcomes of this demonstration waiver.

A. Health

Does the waiver program, through expanded access to a comprehensive pharmacy benefit and sophisticated benefit management tools, reduce the utilization of acute health care services such as inpatient hospital services and nursing home services by the low-income elderly population?

The waiver population consists of a diverse group of those ages 65 and older. Since health is difficult to quantify and generally declines with age, accurate measurement of the health benefits associated with this demonstration project is complicated. The Commonwealth, however, will use indirect indicators, such as utilization of publicly funded benefits and survey research methods to assess the outcomes associated with this waiver program. The "health" principles for evaluation and their premises are:

1. Prescription drugs promote and maintain health for those ages 65 and older. The Commonwealth will offer access to prescription drugs for this group of people, whose income is at or below 188% FPL. The number of individuals who are 65 and older, eligible for this prescription benefit will be established. The aggregate number will serve as a baseline measure and a benchmark for evaluating the success of the program in reaching and enrolling eligible individuals (demonstration population).

2. Utilization rates will indirectly measure the health outcomes of the demonstration population. The basis of this measure is founded on the assumption that health is associated with reduced use of inpatient hospital services, nursing home care and other medical services provided to the Aged and Disabled population. Massachusetts, therefore, will monitor pre- and post- demonstration inpatient hospital, nursing home utilization data and other medical services for these populations. Rates will be adjusted for patient mix to more accurately assess outcomes associated with the waiver.

B. Resources

Is there a reduction in the utilization of and dollars spent on non-pharmacy services for program participants as a result of the expanded access to necessary medications?

Increasing access to prescription drug benefits will help increase the quality of primary care and decrease adverse health outcomes associated with the lack of proper and sufficient medications for these populations. Outlays incurred by providing this benefit, therefore, will be offset by the savings generated from fewer hospital and nursing home stays (and other home health/long-term care services) and a possible decrease in emergency room services associated with

improper patterns of medication usage. The "resource" principles for evaluation and their premises are:

1. Prescription drugs used appropriately are a medical expense that will decrease use of other health care services. Prospectively, Massachusetts will collect and compare rates of use of health care services, including those listed below, between low-income seniors with and those without a prescription drug benefit. Savings associated with the conservation of these healthcare resources will be calculated. Services which may be included are those provided by:
    a. Nursing homes and other longer term care providers
    b. Inpatient hospitals
    c. Outpatients
    d. Emergency rooms

2. Trending will monitor the waiver program's ability to maintain or decrease MassHealth enrollment for those ages 65 and above.

C. Health Policy

Are the cost savings associated with this program sufficient to influence larger Medicaid or Medicare policy and planning?

As can be seen from research principles and premises previously mentioned, the information gathered during the evaluation process will be useful for future health care policy and planning not only in Massachusetts, but also nationally. Specifically, the "health policy" principles for evaluation and their premises are:

1. The waiver population includes individuals who likely mirror the Medicare population in age . The demonstration outcomes and data will therefore be relevant to the national debate regarding the addition of a Medicare prescription drug benefit. Cost-effectiveness analysis will yield the value of pharmaceutical interventions for seniors.

2. The Commonwealth will help promote improved health outcomes of its low-income citizens and reduce the (state and Federal) costs associated with providing health care to this segment of the population. This will free health care dollars that policy makers may allocate to other areas of health care.

D. Data Sources

The evaluation component of this waiver will require data from numerous sources. The evaluation will begin after the first year of the program. The evaluation process will draw on data on services used prior to and throughout the participants' enrollment in the program, when available, as well as national data sources. Data on services used prior to

enrollment in the demonstration program will allow for the formation of baseline measures and benchmarks. Data sources may include:

1. *Case Study Interviews, Focus Groups and Surveys*: Structured longitudinal interviews and/or surveys could be used to examine changes in health status and utilization of healthcare services. Surveys or interviews and focus groups could also be used to aggregate information pertaining to perceived changes in quality of life and current and historic utilization of prescription drugs. Survey or interview results would be used in conjunction with data obtained from other sources to evaluate the success of this Research and Demonstration project.

2. *Medicaid Claims Data*: Medicaid claims data for program participants will provide information regarding participant's demographics, prescriptions filled, total number of waiver participants and waiver expenditures. This data could be cross-referenced with Medicare data.

3. *Medicare Claims Data*: This data is necessary to establish changes in utilization patterns for demonstration participants enrolled in Medicare. Medicare's comprehensive database could be used to query data for both waiver and non-waiver participants to evaluate utilization patterns and other relevant factors.

4. *Vital Statistics Reports and Census*: Data from entities such as the Massachusetts Department of Public Health, the Centers for Disease Control and Prevention and the Census Bureau may be used for benchmarking. These data can be used to compare outcomes of program participants, such as standardized mortality ratios, to the state as a whole and to the nation.